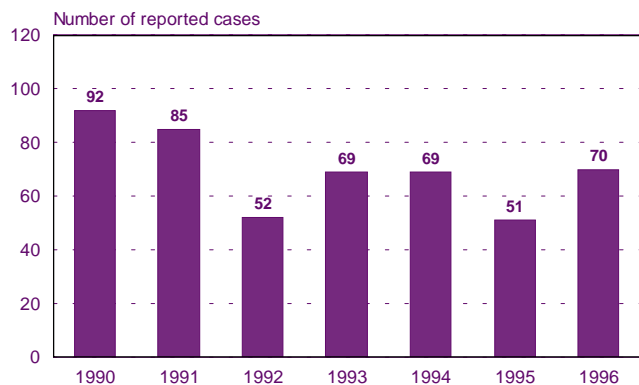


Meningococcal disease: When might we vaccinate?

Cases of meningococcal illness in Massachusetts have been highly publicized over the last few months. Although media attention has led many to believe the occurrence of the illness has increased, ongoing surveillance indicates that sporadic cases of meningococcal illness continue to occur throughout the state at a rate comparable to previous years (see graph below). Surveillance of meningococcal disease includes determination of the serogroup causing disease and analysis of the occurrence of disease by person, place and time.

Meningococcal Disease

Massachusetts, Reported Cases 1990 - 1996



*1996 data are provisional

There has also been speculation about the possible use of meningococcal vaccine for prevention. A meningococcal vaccine (against serogroups A, C, Y, W-135) is available, but routine vaccination is not recommended in the U.S. The Advisory Committee on Immunization Practices (ACIP) recommends meningococcal vaccine for travelers to countries with endemic disease and for certain high-risk individuals.

The ACIP has recommendations for the possible use of vaccine in cases of either institution- or community-based outbreaks of meningococcal disease. Vaccination may be considered when at least three cases of meningococcal disease of the same serogroup occur in individuals who are **not** close contacts of each other **and** the rate of disease is greater than 10 cases per 100,000 population. The cases must be part of a definable population (an institution or community) and have onsets of illness within a three-month period. The serogroup causing illness must be included in the vaccine. Many experts question the value of vaccination even for such outbreaks of meningococcal disease. In outbreaks

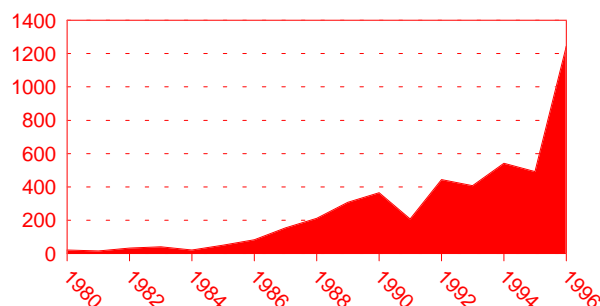
(Continued on page 5)

Pertussis on the rise Adolescents at risk

Reported cases of pertussis in Massachusetts reached 1,243 in 1996. This is a 2.5-fold increase over the 492 cases reported in 1995 (see graph below) and is the highest number of cases reported in the state since 1958. Since reporting began in 1894, the all-time high was 13,333 cases in 1937, before the vaccine was available. The recent increase in reported cases is likely due, in part, to improved surveillance and greater awareness of pertussis among health care providers.

However, based on national morbidity reporting data and state-based laboratory testing data, the true incidence may also be increasing. Nationally, reported cases increased to over 6,900 for 1996. Pertussis occurs in cycles, with peaks every three to four years, and 1996 may mark the beginning of a persistent upswing.

Pertussis in Massachusetts 1980 - 1996*



*1996 data are provisional

The number of specimens submitted to the State Laboratory Institute (SLI) for diagnostic testing in 1996 roughly doubled since 1994. The *proportion* of specimens with positive results also increased, suggesting that pertussis incidence in Massachusetts is, in fact, on the rise. The percentage of cultures submitted that tested positive rose from 4.2% in 1994 to 8.9% in 1996.

(Continued on page 5)

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Epidemiology Update

New quarantine policy for ferrets



Now that ferret ownership is legal in Massachusetts, more people are likely to be bitten, scratched or otherwise exposed to ferrets. In light of studies on shedding periods of rabies virus in ferrets, the Massachusetts Department of Public Health has decided that, **effective immediately**, a 10-day rabies quarantine period for ferrets will be recommended under certain circumstances.

According to the new policy, ferrets that bite or scratch people or whose saliva touches a person's mucous membranes, fresh cuts, or scratches will be quarantined for 10 days, just like dogs or cats. Pet store ferrets that expose people will not be released to new owners until the 10-day quarantine period is complete. The purpose of the quarantine is to observe the animal for signs of rabies. A ferret that has rabies virus in its saliva should show signs of rabies within 10 days.

If any of the following circumstances exist, the ferret should be euthanized immediately and tested for rabies instead of being quarantined for 10 days: 1) the ferret has signs consistent with rabies (*e.g.*, neurologic signs), or it develops signs consistent with rabies during a quarantine period; 2) the ferret is demonstrating behavior that is unusual for the particular ferret; 3) for any reason, the ferret dies during the 10-day quarantine period. For rabies testing, the head should be submitted to the Massachusetts State Laboratory Institute.

This quarantine period would apply regardless of the vaccination status of the animal. Ferret quarantines are handled by the Massachusetts Department of Fisheries, Wildlife and Environmental Law Enforcement (617-727-3151).

Never too old for Fifth Disease

Fifth Disease is a well-recognized and relatively common infection, with frequent outbreaks among children in the spring. The diagnosis of Fifth Disease may be overlooked in adults, however, because its presentation may differ and because it is thought to be only a childhood disease. Many adults are immune because they were infected in childhood, symptomatically or asymptotically. However, up to 50% of adults may still be susceptible to human parvovirus B19 (the etiologic agent of Fifth Disease). Parvovirus B19 infection in pregnant women can cause fetal hydrops. The estimated risk of fetal death under 10% for infections in the first half of pregnancy and negligible in the second half, and infection during pregnancy has not been reported to cause congenital anomalies.

Parvovirus B19 infection in adults can present as erythema infectiosum (EI), characterized by mild systemic symptoms (sometimes with fever) and frequently a rash involving the face and neck (often with red cheeks and circumoral pallor) and the limbs and trunk (maculopapular, lace-like rash). The rash can recur and fluctuate in intensity with external stimuli (*e.g.* temperature, exposure to sunlight) for weeks. The rash may look like rubella. Arthralgia and arthritis, sometimes in the absence of EI, occur commonly in adults, especially women. Parvovirus B19 infection can also cause a mild respiratory illness with no rash or joint symptoms. Transmission of the virus is believed to involve respiratory secretions. Most transmission, if not all, occurs before rash onset. The virus is occasionally transmitted through blood transfusions. The incubation period to development of prodromal symptoms and then rash is generally 4–14 days, but it can be as long as 20 days.

What's biting you?



Massachusetts and other New England states documented two to three times as many cases of Lyme disease and other tick-borne diseases in 1996 as in 1995. Although the reason is uncertain, it was likely due to the wet weather in the spring and summer of 1996, which provided ideal habitat for ticks. Whether cases of Lyme disease and other tick-borne diseases (such as Rocky Mountain spotted fever, babesiosis, ehrlichiosis, and tularemia) will be higher than usual in 1997 remains to be seen.

With the arrival of spring, ticks seek mammalian hosts for blood meals. All Massachusetts residents should understand that tick bites are risky and take measures to prevent them.

The deer tick, which carries Lyme disease, babesiosis, and ehrlichiosis, is the tick most likely to bite humans. This tick is the size of a poppy seed, so it is easy to overlook. To prevent tick bites, take the following precautions:

Don't walk bare-legged in tall grass, dunes, or woods where ticks may live.

Light-colored clothes will make the dark brown ticks easier to spot.

Use an insect repellent containing no more than 30–35% DEET on adults and no more than 10–15% DEET on children. **Do not use insect repellants on infants.** On children, do not apply repellent to the hands or face and wash all skin surfaces treated with insect repellent when no longer needed. Alternatively, apply permethrin-containing repellents to clothing (not skin) according to the manufacturer's directions.

Check for ticks every time you come in from outdoors, and check your children often. Look for ticks in all joint areas, along the hairline, behind and in the ears, in the navel, and on the thighs.

To remove a tick, use tweezers to grasp the tick's mouthparts firmly, and pull it straight out using gentle, steady pressure. Squeezing or squashing the tick can force bacteria into the wound. Do not use petroleum jelly, nail polish remover or heat to remove the tick.

STD Update

National STD conference

More than 1,200 people attended the three-day National STD Conference in December to review the national prevention effort, project trends and plan initiatives.

Institute of Medicine report: "Silent Epidemic: STDs in America" reviewed the high rates of STDs in the US compared to other industrialized nations and explored some of the reasons. Issues raised included: the poor understanding of the cost and social impact of STDs; the need for improved clinical education and greater access to comprehensive sex education; poor recognition of the role of STD prevention in HIV prevention; and lack of advocacy for STD prevention. A summary of the report is available from the Division of STD Prevention, (617) 983-6952.

Interactions with HIV: Lesion STDs are an independent risk factor for contracting HIV infection. Dramatic findings from Africa demonstrated that preventing or curing lesions reduced HIV transmission by 41%. Copies of this article are available from the Division of STD Prevention.

Managed Care: The number of poor and uninsured now being covered by managed care organizations raises many questions. What is the future for specialized public health services like STD clinics? Who will set standards of care? Will people be diagnosed or treated presumptively? Will screening be defensible from a cost perspective? Who will be responsible for partners? These, among other questions, need to be resolved as managed care coverage continues to expand rapidly.

Women and STDs: Focus on women, especially the need for women-controlled prevention, was a theme throughout the conference. Presentations included an update on the female condom and microbicide research (both within the US and abroad), as well as studies of behavioral components of prevention programs for women.

Clinic Expansion: Clinics need to link with community-based organizations for active outreach and marketing. They also need satellite locations to increase accessibility.

Behavioral Theory: Incurable viral STDs have refocused interest on the determinants of behavior change, which are at the core of prevention efforts. This is a paradigm shift for STD services, which have historically been based on a clinical, curative approach.

Prisons: Prevention programs need to be enhanced in our nation's prisons and jails.

Clinical Education: STD prevention is enhanced by clinicians who are able to assess risk and are quick to suspect and diagnose STDs. These clinicians need the support of skilled laboratory professionals. More educational opportunities need to be available to such professionals.

Advocacy: STD prevention efforts receive little political advocacy. Sensitivity about sex and sexuality, plus an attitude of blaming the victim, make STDs seem like political quicksand. Advocacy is important to generate more support for prevention and control initiatives.

Not for guys only A female-controlled condom

STD clinics have obtained 15,000 female condoms for distribution. The female condom is a thin polyurethane (not latex or rubber) sheath or "condom" that is placed inside a woman's vagina with the closed end placed inside on the cervix, and the open end outside the vagina. Both ends have flexible rings to keep the condom in place.

The female condom has several advantages. It can be inserted prior to any sexual activity and gives women more control than traditional condoms. In addition, no medical appointment, prescription or fitting (such as for diaphragms) is required. Some studies indicate that protection is used more often when the female condom is included as an option.

Some people have been concerned that the female condom may be difficult to use. However, a large study is currently being conducted by the University of Alabama in which the female condom is supplied free, along with counseling and education. Initial results indicate that the female condom can become more user-friendly with familiarity and practice.

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For a free subscription, please call Debra Thimas at (617) 983-6800.

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You be the epi!

You are the school nurse at an elementary school. A fourth-grade teacher sends you a child who has a red rash near the scalp that began that afternoon. He has a temperature of 100.8°F and lesions that are mostly maculopapular, although a few are vesicular. You suspect chickenpox and promptly send him home. The next day, his parents call to report a physician diagnosis of chickenpox.

After interviewing the teacher, you learn that the case worked closely with several other pupils on an art project over the past two days, and tutors several kindergarten students every day after school. His teacher is two months pregnant and unsure of her chickenpox history.

Your records show that most fourth graders have a reliable history of chickenpox or varicella immunization. However, one of the exposed kindergarten students has not had varicella, and her varicella vaccination status is unknown. You learn that this child lives with a younger sibling who is immunocompromised.

Given the high communicability of varicella and potential for complications in certain higher-risk groups, what should you do regarding the case and his close contacts at the school?

Analysis

The case should be excluded from school until the end of his infectious period, until all lesions are crusted over (usually five days after rash onset). He exposed a few healthy susceptible fourth graders, especially those working on the art project. You should make parents aware of this possible exposure to varicella in that classroom.

The pregnant teacher should be advised to contact her obstetrician regarding serologic testing for varicella immunity. The use of varicella immune globulin (VZIG), if administered within 96 hours after exposure, can help to modify disease and decrease risk of severe complications of chickenpox, (e.g., pneumonitis, encephalitis, hepatitis, pancreatitis).

The susceptible kindergarten student is a household contact of an immunocompromised individual whose immune status against varicella is unknown. The parents of this susceptible student should be informed of the exposure and advised to consult with the health care provider of their immunocompromised child. This provider will determine the child's susceptibility and advise on any control measures. If susceptible, the immunocompromised child is at great risk for serious complications of chickenpox, which is why the kindergarten student should be vaccinated against chickenpox. While it is not currently known whether post-exposure vaccination will prevent illness in the kindergarten student or prevent transmission to her sibling, there is no harm in vaccinating a person who might be incubating varicella virus.

Confidentially speaking



Electronic modes of data storage, manipulation and transmission are having a dramatic impact on how we conduct business. The new technology has also created new issues and increased concern regarding confidentiality. However, new technology has also offered some solutions to the problems it raises.

The State Laboratory Institute (SLI) is reinforcing and upgrading data security. If you visit the SLI, you will notice changes affecting parking and building security. All employees are being issued new identification badges containing encrypted magnetic strips. These badges will provide access to the parking areas, which are being fitted with gates. Visitor parking will be restricted to an area in front of the building. The badges will also be needed to enter the building. Eventually, smart cards will control entry to parts of the building where data are stored. Visitors will stop at the front desk to sign in, and they will be escorted to their destination. Space in the building is being re-configured so that we can eliminate the use of trailers, which are difficult to secure from break-ins.

The Bureau of Communicable Disease Control is also in the midst of reviewing its own policies and procedures for protecting confidentiality. A Working Group has been convened to update the Bureau's Confidentiality Policy. This group will examine: physical measures; data access (e.g., use of networks); passwords for databases and individual files; data transmission (e.g., faxes in secured areas with limited access); data release (the balance between protecting individual confidentiality vs. public right to know); materials disposal (shredded, burned or tossed into the trash); and research projects.

"Confidentially Speaking" will be a recurring column for discussion of these issues. Perhaps it will prompt some review of how you protect information. We would also welcome hearing from you about some of your deliberations and solutions, so we might pass them along to all of our readers. "Loose Lips Sink Ships" is a slogan and exhortation from another time, but it is no less true for us today.

Pertussis

(Continued from page 1)

For serologic specimens, the percentage positive increased from 14% in 1994 to 19.3% in 1996.

Nationally, as well as in Massachusetts, the number of pertussis cases has been gradually rising since the late 1970s. One hypothesis is that, with pertussis vaccine coming into widespread use in the 1950s, the proportion of people who have natural lifelong immunity from having had the disease is decreasing. In contrast to natural immunity, protection from vaccine wanes and is absent 12 years after the last dose of DTP, which is usually given at kindergarten entry. This has resulted in a susceptible population now predominantly made up of adolescents and adults. Waning herd immunity allows the organism to establish itself and spread. The upward trend in pertussis cases would therefore be expected to continue until a vaccine is licensed for use in those seven years of age and older.

The pattern of age groups affected by pertussis is also changing. Nationwide, the proportion of cases occurring in people older than 10 years has increased from about 10% in the 1980–83 period to about 30% in the 1994–96 period. In Massachusetts, most reported cases occur in adolescents. In 1996, 64% of cases were in the 11–19 year old age range, up from 54% in 1995. However, reporting bias may contribute to the high proportion of adolescent cases; health care personnel in school settings are able to do more careful surveillance than is possible in most adult settings.

Institutions may facilitate disease transmission. In 1996 there were 19 pertussis outbreaks (≥ 5 clustered cases) in Massachusetts. Of these, 17 occurred in high schools or middle schools. (See related article, "Pertussis Epi-Aid.") The remaining two outbreaks occurred in a residential home for the developmentally disabled and an acute-care hospital. Of additional concern, 22 cases of pertussis occurred in health care settings and involved both staff and patients.

Given recent epidemiologic trends, pertussis must be considered in the differential diagnosis for all individuals who present with a prolonged cough illness. Adolescents and adults can transmit pertussis to unimmunized and under-immunized infants and young children, who are still at greatest risk for complications (including pneumonia, seizures, and death). Although waning immunity leaves adolescents and adults susceptible, age-appropriate immunizations will help limit the occurrence of disease in young children.

AIDS news

Readers of *Communicable Disease Update* have asked why we do not carry information on AIDS. The reason is that the Massachusetts Department of Public Health already publishes a newsletter specific to this topic, the *AIDS Quarterly Review*. This publication is a collaboration between the HIV/AIDS Bureau and the AIDS Surveillance Program. For a free subscription, please call the AIDS Surveillance Program at (617) 983-6560.

Pertussis Epi-Aid: Helping hand from CDC

By Raffi Tachdjian, MPH

National Immunization Program, CDC

The U.S. Centers for Disease Control and Prevention (CDC) was asked by the Massachusetts Department of Public Health (MDPH) to assist with the investigation of a school experiencing a pertussis outbreak. The main objectives of the Epi-Aid were to assess risk for pertussis disease and evaluate control measures in school settings.

In this suburban high school chosen for more extensive investigation, 77 (7.6%) cases of pertussis were detected among a total of 1,009 students. Of these cases, 11 were culture proven, 17 were serology positive, and 35 cases were epidemiologically linked to either a culture or serology positive case. We assessed attack rates by grade level, sports team, and time since last vaccination for all students attending during school year 1996–97. Help was provided to the CDC team by the school nurses. Analysis is ongoing.

The MDPH and CDC are collaborating on a Pulsed-Field Gel Electrophoresis (PFGE) study to determine whether this is a community- or a school-based outbreak of pertussis. PFGE typing is a state-of-the-art laboratory method that identifies the specific strain of *Bordetella pertussis*. Seventy-nine culture positive cases, some of which were household contact cases as well as sporadic cases, were identified from around the state, and cultures are being shipped to the CDC laboratory for PFGE strain identification. The results of these analyses will be combined with epidemiological data to evaluate whether strains circulating in the school were different from strains circulating in other regions of Massachusetts.

Streamlining of surveillance efforts is currently being discussed, in hopes of expediting case investigations during outbreaks. The outcomes of the Epi-Aid should help improve our understanding of pertussis epidemiology in school settings, help determine the roles of waning vaccine-induced immunity, provide important information on outbreak control, and help improve the efficiency of pertussis case investigations.

Meningococcal

(Continued from page

1)

involving a small, defined population (e.g., a school), chemoprophylaxis may be a preferred means of prevention.

Surveillance for meningococcal illness is ongoing, with a high priority placed on the identification of potential outbreaks. Prompt reporting of suspect and confirmed meningococcal disease and submission of bacterial isolates to the State Laboratory Institute for grouping will aid in the rapid identification of potential outbreaks. If you have questions or would like copies of the ACIP statements on meningococcal disease, please call the Epidemiology Program at (617) 983-6800.

Immunization Update

Springfield's new team targets tots

During the spring of 1994, the mayor, health department, health care providers, business leaders and human service executives, began looking at ways to create a healthier Springfield. Meeting monthly for the past two years, the Springfield Community Health Planning Steering Committee has completed its first planning cycle.

Recognizing that Springfield faces numerous complex health, social and economic problems, the Committee realized that no single organization could solve them alone. With this in mind, a not-for-profit organization, Partners for a Healthier Community (PHC), was formed in October of 1996 to oversee the first three child- and family-focused programs: 1) Immunization Tracking, Outreach and Education Program; 2) Comprehensive School Health Program; and 3) Youth Development Program.

PHC is currently implementing outreach and education projects as a first step towards improving the well-being of preschool-aged children in Springfield, according to Don Frigon, of Baystate Health Systems. In Springfield, rates of teen pregnancy, sexually transmitted diseases, and infant mortality are in many cases double the state average. Pilot projects to reach and support vulnerable families are underway. The goal is to achieve 90% immunization rates for children under two, to link families to health care providers, and to conduct neighborhood outreach using residents as community health advocates.

The SHOTS (Starting Healthy: Our Task for Springfield) Immunization Program is the first step toward improving the health of Springfield's neighborhoods. This immunization program is designed to train community health advocates, establish a model provider network, and develop a computer system to track immunization histories.

For more information, contact Partners for a Healthier Community, P.O. Box 4895, Springfield, MA 01101-4895 or call (413) 784-2272.

New sequential polio vaccine schedule

The Advisory Committee on Immunization Practices (ACIP) recently recommended a sequential vaccination schedule of two doses of inactivated poliovirus vaccine (IPV) followed by two doses of oral poliovirus vaccine (OPV) for routine vaccination of children in the U.S. The ACIP made this recommendation for the following reasons: 1) paralytic polio from indigenously-acquired wild poliovirus has not occurred in the U.S. since 1979; 2) progress toward global eradication has reduced the risk for importation of wild poliovirus into the U.S.; and 3) vaccine-associated paralytic poliomyelitis continues to occur.

The Massachusetts Immunization Program (MIP) now provides IPV and OPV for all children. Both vaccines are

Hepatitis B and rubella hospital record review

To prevent hepatitis B infection and congenital rubella syndrome, the CDC Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics recommend prenatal HBsAg and rubella testing, and hepatitis B and postpartum rubella immunization. The Massachusetts Hepatitis B Prevention Project conducted a hospital record review on a random sample of 157 paired maternal and infant hospital records statewide to evaluate compliance with these recommendations.

The results indicated that: 98.1% of pregnant women were tested for HBsAg and 99.4% were tested for rubella. While 88.5% of the infants received hepatitis B vaccine prior to discharge, only 60.1% of those infants had documentation of the correct dose of vaccine; 66.6% of rubella-susceptible women were vaccinated prior to discharge.

Although these results indicate high compliance with state and federal recommendations, improvement is needed in documentation of hepatitis B vaccine doses and immunization of rubella-susceptible postpartum women.

Recommendations

- If maternal HBsAg status is unknown, test the mother and immunize the infant with a dose of hepatitis B vaccine appropriate for an infant born to a HBsAg-positive mother. If the mother is found to be HBsAg-positive, administer HBIG as soon as possible, within 7 days of birth.
- Document the dose (in micrograms) and manufacturer of hepatitis B vaccine in the newborn's record.
- Immunize all rubella-susceptible postpartum women with MMR vaccine prior to discharge.

To obtain a detailed summary, sample standing orders for hepatitis B and MMR vaccination, please call Louisa Bell Paushter at (617) 983-6800.

ordered by using the Vaccine Order Form. Providers no longer need to use the *Enhanced-Potency Inactivated Poliovirus Agreement* to order IPV or the *E-IPV Doses Administered Report* to record IPV usage. Both OPV and IPV usage should now be recorded on the standard *Vaccine Usage Report* (green bubble sheet).

While the sequential schedule is recommended, an all-IPV or all-OPV schedule is acceptable. Parents should be informed of the polio vaccines available, the three alternative schedules, and the basis for the polio vaccination recommendations. Revised Vaccine Information Statements and other polio vaccine information materials are available through the regional immunization offices.

TB Update

Reaching out

Outreach Workers (ORWs) have a significant role in many health care programs. Since 1984, the Division of Tuberculosis Prevention and Control has been fortunate to work with and learn from its outreach staff. Historically, ORWs have been recruited from communities at high risk for tuberculosis (TB). Currently, there are seventeen ORWs, six of whom are permanently assigned to the Refugee & Immigrant Health Program. They are from varied cultural backgrounds.

ORWs are instrumental in locating patients lost to follow-up, educating patients, encouraging patients to complete recommended treatment, assisting local public health nurses in screening close contacts, and establishing and maintaining trusting one-to-one relationships with patients that help them adhere to prescribed treatment regimens. They also provide interpreter services in both the clinic and the community.

In response to rising TB case rates and increased drug resistance, the CDC encourages the use of Directly Observed Therapy (DOT) for persons with active TB disease. Adherence to therapy reduces the risk of drug resistance and increases completion of treatment. DOT may be performed by nursing staff or other trained health care professionals and involves watching a patient take each dose of prescribed antituberculosis medication. A number of states adopted universal DOT protocols; that is, all patients diagnosed with active disease are placed on DOT.

Massachusetts chose an individualized approach. Accordingly, each patient is assessed for factors that may indicate a potential for nonadherence; *e.g.*, substance abuse, history of nonadherence. If there is no identified risk, patients are placed on self-administered therapy. When needed, DOT is usually performed in the patient's home, although it can be administered at the clinic or health department. ORWs are invaluable in the success of DOT programs and are given specific training regarding DOT and antituberculosis medications, and related side effects. DOT assists patients in completing treatment, and equally important, the ORWs give support and encouragement to patients.

"Often, I visit this family early in the morning and talk to them," one of the ORWs recently stated. "They look forward to my visit. I am a part of these people's lives. And that means a lot to the people I am serving,



Northeast region: Tuberculosis Surveillance Area (TSA) III

TSA III Nurse: Nancy Taylor Flynn, RN, BSN

Epidemiology: In 1996, 41 cases of *Mycobacterium Tuberculosis* were identified in TSA III as compared to 69 cases in 1995.

Clinical Services: In 1996, the clinic in Lynn merged with the Northshore Pulmonary Clinic located at Salem Hospital. Shuttle buses provide transportation for patients from Lynn.

The geographical boundaries of the TB regions were changed to match those of other state agencies. Lynnfield, Melrose, North Reading, Reading, Stoneham and Wakefield are now part of TSA III. These towns were referred to the Middlesex County Hospital TB clinic for services prior to the clinic's closure in late 1996. Patients from these towns have now been reassigned to other existing clinics until a new clinic site is established. Other clinic sites in TSA III are at Lawrence General Hospital, Malden Hospital, and Saints Memorial Hospital in Lowell.

Educational Activities: Twenty-six educational inservices were provided in 1996, primarily to employees in long-term care facilities, hospitals, and Visiting Nurse Associations. In addition, ten educational inservices have been provided to date in 1997. The regional TB update was held at Lawrence General Hospital in September 1996. The next update is tentatively scheduled for September 24, 1997; location to be announced.

Outreach Activities: Community outreach workers (ORW) for TSA III are Antonio Ramos, Joanny Perez and Bill Wong. Bill works with the Chinese population, primarily in Malden; Antonio and Joanny speak fluent Spanish. Carmen Gorman, a former ORW in TSA III, has recently been promoted to the Prevention Coordinator for TSAs II and III. Among her new duties, she will conduct source case investigation follow-up for infected children 4 years and younger.

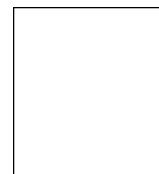
We are on-line

The Massachusetts Department of Public Health's web site is up and running. It includes a variety of communicable disease fact sheets from the Division of Epidemiology & Immunization and the Division of Sexually Transmitted Disease Prevention that can be viewed and printed. Other material that can be accessed are editions of *The Reporter* from the Division of Food & Drugs and vital statistics from the Division of Vital Statistics. Much more information will be available in the future, including editions of *Communicable Disease Update*. The MDPH homepage address is:

<http://www.magnet.state.ma.us/dph/>

Communicable Disease Update

State Laboratory Institute
305 South St.
Boston, MA 02130



Communicable Disease Updates: 1995 vs. 1996 Reported Cases

DISEASE	1995	1996*	% change from 1995
AIDS	1098	648	-41%
Botulism	1	0	-100%
Campylobacter	1,588	1,462	-8%
Chlamydia	7,402	6,791	-8%
Cryptosporidiosis	131	84	-36%
<i>E. coli</i> O157:H7	118	162	+37%
Giardiasis	1,040	954	-8%
Gonorrhea	2,658	2,163	-19%
Hepatitis A	161	226	+40%
Hepatitis B (acute)	114	104	-9%
Lyme Disease	189	375	+98%
Measles	5	12	+140%

* Preliminary data. Reporting not yet complete.

DISEASE	1995	1996*	% change from 1995
Invasive Meningococcal Disease (Neisseria)	51	70	+37%
Pertussis	492	1,243	+153%
Rabies (animal)	401	114	-72%
Rubella	11	21	+91%
CRS**	0	0	—
Salmonellosis	1,862	1,655	-11%
<i>S. typhi</i> (Typhoid)	31	18	-42%
Shigellosis	324	263	-19%
Syphilis (early)	223	262	+17%
TB	330	262	-21%

** Congenital Rubella Syndrome

Save the dates!

Massachusetts Immunization Action Partnership (MIAP) Annual Meeting

May 1, 9–3:30 PM, Best Western Hotel, Marlboro. For more information call Mimi Larzelere at (617) 624-6146.

Infection as a Community Problem

May 28. Sponsored by the Massachusetts Public Health Association and the MDPH Bureau of Communicable Disease Control. Part I, 8 AM–12 noon, \$25: Prevention of foodborne, waterborne, airborne and vectorborne diseases and new issues in rabies control. Part II, 1:30–3:30 PM, special optional session, free: Roundtable discussion of recent issues of importance to local boards of health and health department staff. To be held at Tufts Affiliated Health Plan, Waltham. Registration required; CEUs available. For more information call the MPHA at (617) 524-6696.

CDC Satellite Training Course: Epidemiology and Prevention of Vaccine-Preventable Diseases

(Four-day comprehensive course) June 5, 12, 19, and 26, 12–3:30 PM. Special session on June 12: Update on Pertussis and Polio Vaccines. To be held at the State Lab Institute, Jamaica Plain. CEUs available. For more information call Walt Lasota at (617) 983-6834.

Massachusetts Department of Public Health's 1997 Teleconference Series on Infectious Disease:

Enterics: Laboratory & Epidemiology Considerations.

May 21, 1–2 PM, \$25 fee. Preregistration is required, deadline is May 7, 1997. The only equipment needed to access the programs is a speaker phone. CEU's available.

Gram Positive Organisms: Susceptibility Testing. July TBA

Pertussis: Diagnosis & Surveillance. September TBA

TB Rapid Diagnostics: Practical or Not? November TBA

For more information, call the National Laboratory Training Network, New England Office at (617) 983-6284 or 1-800-536-NLTN (within New England).